provide agency flexibility. GSA is leading three working groups comprised of representatives from Federal agencies to revise those areas of the FTR which pertain to Temporary Duty (TDY) Travel Allowances that include special conveyances, per diem and air transportation. The purpose of this notice is to announce that the working groups will hold a public meeting to receive information from industry and the public on best practices in the aforementioned areas.

DATES: The meeting will take place on September 7, 2011 and September 8, 2011.

FOR FURTHER INFORMATION CONTACT: Ms. Marcerto Barr, GSA, 1275 First Street, NE., Washington, DC 20417; telephone: (202) 208–7654; or e-mail: *Marcerto.Barr@gsa.gov.*

SUPPLEMENTARY INFORMATION:

Background

The U.S. General Services Administration under applicable authorities, such as 5 U.S.C. 5707; 20 U.S.C. 905(a); 31 U.S.C. 1353; 40 U.S.C. 121(c); 49 U.S.C. 40118; E.O. 11609, as amended; 3 CFR 1971–1975 Comp., p. 586; and E.O. 13563, is currently addressing the following categories of the FTR Chapter 301- TDY Allowances and related appendices: special conveyances (includes ground transportation and rental cars), per diem (includes meals, incidental expenses, and lodging), and air transportation (includes common carriage transportation). GSA is leading three working groups comprised of Federal agency representatives to address these categories. The last major rewrite of the FTR took place in 1998.

Meeting Details

Place: The 2-day public meetings will be held at the GSA Auditorium, 1800 F Street, NW., Washington, DC 20405. The meeting is open to industry and the general public beginning at 10 a.m. EST through 4 p.m. EST.

Attendance: The event is open to the public based upon space availability. Attendees and speakers must pre-register. A limited number of speakers will be allowed to make oral presentations based upon space and on a first-come, first-serve basis. Additionally individuals are welcome to submit written materials to the working groups.

Pre-Registration: To pre-register, as an attendee or speaker contact Ms. Barr as detailed above. Participants interested in speaking should indicate the category you would like to address, your name, company name or organization (if applicable), telephone number and email no later than the close of business on August 23, 2011.

Agenda: Presentations from industry and the public will be time limited. Each registered presenter will be allotted a total of 20 minutes.

Statements and Presentations: Send written or electronic statements and requests to make oral presentations to the contact person listed above. Submissions must be provided to Ms. Barr at *Marcerto.Barr@gsa.gov* no later than the close of business on August 23, 2011.

Information on Services for Individuals with Disabilities: Individuals requiring special accommodations at the meeting, please contact Ms. Barr no later than the close of business on August 23, 2011.

Dated: July 14, 2011.

Janet C. Dobbs,

Director, Office of Travel, Transportation & Asset Mgmt.

[FR Doc. 2011–18305 Filed 7–19–11; 8:45 am]

BILLING CODE 6820–14–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

45 CFR Part 156

[CMS–9983–P]

RIN 0938–AQ98

Patient Protection and Affordable Care Act; Establishment of Consumer Operated and Oriented Plan (CO–OP) Program

AGENCY: Department of Health and Human Services.

ACTION: Proposed rule.

SUMMARY: This proposed rule would implement the Consumer Operated and Oriented Plan (CO–OP) program, which provides loans to foster the creation of consumer-governed, private, nonprofit health insurance issuers to offer qualified health plans in the Affordable Insurance Exchanges (Exchanges). The purpose of this program is to create a new CO–OP in every State in order to expand the number of health plans available in the Exchanges with a focus on integrated care and greater plan accountability.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on September 16, 2011.

ADDRESSES: In commenting, please refer to file code CMS–9983–P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (please choose only one of the ways listed):

1. *Electronically.* You may submit electronic comments on this regulation to *http://www.regulations.gov.* Follow the ''Submit a comment'' instructions.

2. *By regular mail.* You may mail written comments to the following address only:

Centers for Medicare & Medicaid Services, Department of Health and Human Services, *Attention:* CMS–9983–P, P.O. Box 8010, Baltimore, MD 21244–8010.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments to the following address only:

Centers for Medicare & Medicaid Services, Department of Health and Human Services, *Attention:* CMS–9983–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

4. *By hand or courier.* Alternatively, you may deliver (by hand or courier) your written comments only to the following addresses prior to the close of the comment period:

a. For delivery in Washington, DC—

Centers for Medicare & Medicaid Services, Department of Health and Human Services, Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201.

(Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without Federal government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

b. For delivery in Baltimore, MD—

Centers for Medicare & Medicaid Services, Department of Health and Human Services, 7500 Security Boulevard, Baltimore, MD 21244–1850.

If you intend to deliver your comments to the Baltimore address, call telephone number (410) 786–9994 in advance to schedule your arrival with one of our staff members.

Submission of comments on paperwork requirements. You may submit comments on this document's paperwork requirements by following the instructions at the end of the

''Collection of Information Requirements'' section in this document. Comments erroneously mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: Anne Bollinger, (301) 492–4395 for issues related to eligibility and CO–OP standards. Catherine Demmerle, (301) 492–4156 for issues related to conversions and program integrity. Meghan Elrington, (301) 492–4388 for general issues and issues related to loan terms.

SUPPLEMENTARY INFORMATION:

Acronym List

Because of the many terms to which we refer by acronym in this proposed rule, we are listing the acronyms used and their corresponding meanings in alphabetical order below:

CCIIO Center for Consumer Information & Insurance Oversight
CMS Centers for Medicare & Medicaid Services
CO–OP Consumer Operated and Oriented Plan
FACA Federal Advisory Committee Act
HHS Department of Health and Human Services
OIG Office of Inspector General
OMB Office of Management and Budget
PHS Act Public Health Service Act
QHP Qualified Health Plan
RFC Request for Comment
SHOP Small Business Health Options Program

Executive Summary: The Patient Protection and Affordable Care Act, Public Law 111–148, enacted on March 23, 2010 and the Health Care and Education Reconciliation Act of 2010, Public Law 111–152, enacted on March 30, 2010, are collectively referred to in this proposed rule as the ''Affordable Care Act.'' The Department of Defense and Full-Year Continuing Appropriations Act, 2011, Public Law 112–10, which amended the Affordable Care Act, was enacted on April 15, 2011. Section 1322 of the Affordable Care Act created the Consumer Operated and Oriented Plan program (CO–OP program) to foster the creation of new consumer-governed, private, nonprofit health insurance issuers, known as ''CO–OPs.'' In addition to improving consumer choice and plan accountability, the CO–OP program also seeks to promote integrated models of care and enhance competition in the Affordable Insurance Exchanges established under sections 1311 and 1321 of the Affordable Care Act.

The statute provides loans to capitalize eligible prospective CO–OPs with a goal of having at least one CO–OP in each State. The statute permits the funding of multiple CO–OPs in any State, provided that there is sufficient funding to capitalize at least one CO–OP in each State. Congress provided budget authority of $3.8 billion for the program.

This proposed rule: (1) Sets forth the eligibility standards for the CO–OP program; (2) establishes some terms for loans; and (3) provides certain basic standards that organizations must meet to participate in this program and become a CO–OP. The overall approach and intent of this proposed rule is to provide flexibility for organizations to develop and create a CO–OP. Acknowledging the significant variation in market conditions and populations served that CO–OPs will face, CMS encourages diversity in the organizational design and approach.

Starting in 2014, individuals and small businesses will be able to purchase private health insurance through State-based competitive marketplaces called Affordable Insurance Exchanges. Exchanges will offer Americans competition, choice, and clout. Insurance companies will compete for business on a level playing field, driving down costs. Consumers will have a choice of health plans to fit their needs. Exchanges will give individuals and small businesses the same purchasing clout as big businesses. The Departments of Health and Human Services, Labor, and the Treasury (the Departments) are issuing regulations implementing Exchanges in several phases. The first in this series was a Request for Comment relating to Exchanges, published in the **Federal Register** on August 3, 2010. Second, Initial Guidance to States on Exchanges was published issued on November 18, 2010. Third, a proposed rule for the application, review, and reporting process for waivers for State innovation was published in the **Federal Register** on March 14, 2011 (76 FR 13553). Fourth, on July 15, 2011, two proposed regulations were published in the **Federal Register** to implement components of the Exchange and health insurance premium stabilization policies in the Affordable Care Act including one entitled, ''Patient Protection and Affordable Care Act; Establishment of Qualified Health Plans and Exchanges,'' hereinafter referred to as ''Exchanges proposed rule.'' Fifth, additional regulations, including this one, are being published in the **Federal Register** to implement Exchange related components of the Affordable Care Act.

Submitting Comments: Comments from the public are welcome on all issues set forth in this proposed rule to assist CMS in fully considering issues and developing policies. Comments should reference the file code CMS–9983–P and the specific section on which a comment is made.

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period as soon as possible after they have been received, on the following *Web site: http://www.regulations.gov.* Follow the search instructions on that Web site to view public comments.

Comments received in a timely manner will also be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1–800–743–3951.

Table of Contents

I. Background

A. Overview

The CO–OP program provides Federal loans to foster and encourage the creation of new consumer-run, private health insurers in every State that will provide consumers and small businesses with greater choice in the Exchanges starting in 2014. These new consumer-run, private, nonprofit insurers will be a vehicle for providing higher quality care that is affordable, coordinated, and responsive.

B. Statutory Basis for the Consumer Operated and Oriented Plan (CO–OP) Program

Section 1322(a) of the Affordable Care Act directs CMS to establish the CO–OP program to foster the creation of member-governed qualified nonprofit health insurance issuers to offer CO–OP qualified health plans in the individual and small group markets in the States in which they are licensed to offer such plans.

Section 1322(b)(1) of the Affordable Care Act provides that CMS shall provide two types of loans to organizations applying to become qualified nonprofit health insurance issuers: Start-up Loans and repayable grants (Solvency Loans). Start-up Loans will provide assistance with start-up costs and Solvency Loans will provide assistance in meeting solvency requirements in the States in which the organization is licensed to issue CO–OP qualified health plans.

Section 1322(b)(2) provides that in making awards, CMS must take into account the recommendations of the Advisory board further described in section 1322(b)(4) of the Affordable Care Act and give priority to applicants that offer CO–OP qualified health plans on a statewide basis, use integrated care models, and have significant private support.

Section 1322(b)(2) of the Affordable Care Act also directs CMS to ensure that there is sufficient funding to establish at least one qualified nonprofit health insurance issuer in each State and the District of Columbia. It permits CMS to fund additional qualified nonprofit health insurance issuers in any State if the funding is sufficient to do so. If no entities in a State apply, CMS may use funds to encourage the establishment of a qualified nonprofit health insurance issuer in the State or the expansion of another qualified nonprofit health insurance issuer from another State to that State.

Section 1322(b)(2) of the Affordable Care Act also directs any organization receiving a loan to enter into an agreement to meet the standards to become a qualified nonprofit health insurance issuer and any other terms and conditions of the loan awards.

Section 1322(b)(2)(c)(iii) of the Affordable Care Act provides that, if CMS determines that an organization has failed to meet any provisions of the loan agreement or failed to correct such failure within a reasonable period of time, the organization must repay an amount equal to the sum of:

- 110 percent of the aggregate amount of loans received; plus
- Interest on the aggregate amount of loans for the period the loans were outstanding starting from the date of drawdown.

CMS must notify the Department of the Treasury of any determination of a failure to comply with the CO–OP program standards that may affect an issuer's tax-exempt status under section 501(c)(29) of the Code.

Under section 1322(b)(3), Start-up Loans must be repaid within 5 years, and Solvency Loans must be repaid within 15 years. Repayment terms in the award of loans must take into consideration any appropriate State reserve requirements, solvency regulations, and requisite surplus note arrangements that must be constructed by a qualified health insurance issuer in a State to receive and maintain licensure.

Section 1322(c)(1) of the Affordable Care Act defines ''qualified nonprofit health insurance issuer'' as an organization that:

- Is organized under State law as a private, nonprofit, member corporation;
- Conducts activities of which substantially all consist of the issuance of CO–OP qualified health plans in the individual and small group markets in each State in which it is licensed to issue such plans; and
- Meets the other requirements in subsection 1322(c) of the Affordable Care Act.

Section 1322(c)(2) of the Affordable Care Act states that an organization is not eligible to become a qualified nonprofit health insurance issuer if the organization or a related entity (or any predecessor of either) was a health insurance issuer on July 16, 2009. In addition, an organization cannot be treated as eligible to apply for a loan under the CO–OP program if it is sponsored by a State or local government, any political subdivision thereof, or any instrumentality of such government or political subdivision. A CO–OP must be a private, nonprofit health insurance issuer.

Section 1322(c)(3) of the Affordable Care Act establishes governance requirements for a qualified nonprofit health insurance issuer. To ensure consumer control, the governance of the organization must be subject to a majority vote of its members. The organization's governing documents must incorporate ethics and conflict of interest standards to protect CO–OP members against insurance industry involvement and interference. To ensure consumer orientation, the organization is required to operate with a strong consumer focus, including timeliness, responsiveness, and accountability to members.

Section 1322(c)(4) of the Affordable Care Act directs the organization to use any profits to lower premiums, improve benefits, or for other programs intended to improve the quality of health care delivered to its members.

Section 1322(c)(5) of the Affordable Care Act directs that the organization must meet all the State standards for licensure that other issuers of qualified health plans must meet in any State where the issuer offers a CO–OP qualified health plan, including solvency and licensure requirements and any other State law described in section 1324(b) of the Affordable Care Act.

Section 1322(c)(6) of the Affordable Care Act prohibits a qualified nonprofit health insurance issuer from offering a health plan in a State until that State has in effect (or CMS has implemented for the State) the market reforms outlined in part A of title XXVII of the Public Health Service Act (as amended by subtitles A and C of title I of the Affordable Care Act) including but not limited to, the requirements for guaranteed issue and limitations on premium variation.

Section 1322(e) of the Affordable Care Act prohibits representatives of any Federal, State, or local government (or of any political subdivision or instrumentality thereof), and representatives of an organization that was an existing issuer or a related entity (or predecessor of either) on July 16, 2009, from serving on the board of directors of the qualified nonprofit health insurance issuer or a private purchasing council established under section 1322(d) of the Affordable Care Act.

Together, these provisions form the statutory basis for the CO–OP program established under this rule.

C. Purpose of the Consumer-Operated and Oriented Plan Program

Section 1322 of the Affordable Care Act established the CO–OP program to provide loans to foster the creation of new consumer-governed nonprofit health insurance issuers (referred to as CO–OPs) that will operate with a strong consumer focus. The statute divides the loans into two types: loans for start-up costs to be repaid in 5 years (''Start-up Loans'') and loans to enable CO–OPs to meet State insurance solvency and reserve requirements to be repaid in 15 years (''Solvency Loans''). Section 1322(b)(2)(A) of the Affordable Care Act directs CMS to ensure that there is sufficient funding to establish at least one CO–OP in each State and to give priority to organizations capable of offering CO–OP qualified health plans on a Statewide basis. To further ensure the presence of CO–OPs in the Exchanges, section 1301(a)(2) of the statute deems CO–OP qualified health plans offered by a qualified nonprofit health insurance issuer eligible to participate in the Exchanges.

The CO–OP program also seeks to promote improved models of care. Existing health insurance cooperatives and other business cooperatives provide possible models for the successful development of CO–OPs around the country. One major barrier to continued development of this model has been the difficulty of obtaining adequate capitalization for start-up costs and State reserve requirements. The CO–OP program is designed to help overcome this major barrier to new issuer formation by providing funding for these critical activities.

Pursuant to section 1322(b)(4) of the Affordable Care Act, the Comptroller General announced the appointment of a 15 member CO–OP Program Advisory Board to make recommendations to CMS on awarding loans on June 23, 2010. Section 1322(b)(2)(A) directs the Secretary to consider the recommendations of the Advisory Board when awarding loans under the CO–OP program. After taking comments in three day-long public hearings from January through March, 2011 and written comments, the Advisory Board approved its final recommendations and report on April 15, 2011. The Advisory Board's final report is available at: *http://cciio.hhs.gov/resources/files/coop_faca_finalreport_04152011.pdf.* The Advisory Board generally advised the Department to develop flexible criteria that recognize the diversity of market conditions around the country to enable the development of various CO–OP models and allow different types of sponsorship. It also strongly encouraged the Department to provide technical assistance at all stages of the process in order to enhance the viability of individual CO–OPs and the success of the program.

The Advisory Board developed four major principles for awarding loans. CMS concurs with those principles:

(1) Consumer operation, control, and focus must be the salient features of the CO–OP and must be sustained over time;

(2) Solvency and the financial stability of coverage should be maintained and promoted;

(3) CO–OPs should encourage care coordination, quality and efficiency to the extent feasible in local provider and health plan markets; and

(4) Initial loans should be rolled out as expeditiously as possible so that CO–OPs can compete in the Exchanges in the critical first open enrollment period.

CMS also concurs with the Advisory Board in recognizing that potential CO–OPs will initially present different capabilities and levels of development. This proposed rule incorporates the principles endorsed by the Advisory Board by allowing diversity among CO–OPs and maintaining the vision outlined in the Advisory Board Final Report. The CO–OP program will offer an entry point to eligible organizations that seek to provide more consumer-focused coverage and create additional competition for insurance that will make high-quality care more affordable. By creating more health plan choices, CO–OPs can benefit all consumers.

D. Request for Comment

On February 2, 2011, CMS published a Request for Comment (RFC) in the **Federal Register** (76 FR 5774) seeking public comment on the rules that will govern the CO–OP program. The comment period closed on March 4, 2011. CMS has considered and incorporated the comments received in developing specific regulatory proposals.

The public response to the RFC yielded 55 unique comment submissions. A total of 65 unique entities submitted comments, including entities that submitted stand-alone comments and multiple individuals who signed onto one comment submission. The 65 total unique commenters included consumers and consumer advocacy organizations, medical and health care professional trade associations and societies, health insurers and insurance trade associations, health benefits consultants, and actuaries. The majority of the comments related to the types of organizations that would likely become successful CO–OPs and the criteria CMS should use in awarding loans.

E. Structure of the Proposed Rule

The regulations outlined in this Notice of Proposed Rulemaking will be codified in the new 45 CFR part 156 subpart F. The major subjects covered in this proposed rule under subpart F of part 156 are described below.

- Section 156.500 describes the statutory basis of the CO–OP program and the scope of this proposed rule;
- Section 156.505 sets forth definitions for the terms applied in subpart F;
- Section 156.510 specifies the criteria to be eligible for a loan under the CO–OP program;
- Section 156.515 sets forth the standards for a CO–OP; and
- Section 156.520 sets forth the terms for loans awarded under the CO–OP program including repayment terms and interest rates.

II. Provisions of the Proposed Regulations

A. Basis and scope (§ 156.500)

Section 156.500 specifies the general statutory authority for and scope of standards proposed in subpart F. The CO–OP program fosters the creation of qualified nonprofit health insurance issuers to offer CO–OP qualified health plans in the individual and small group markets. Subpart F establishes certain governance requirements for CO–OPs and the terms for loans awarded under the CO–OP program. Applicants may apply for loans to help fund start-up costs and meet the solvency requirements of States in which the applicant seeks to be licensed to issue CO–OP qualified health plans.

B. Definitions (§ 156.505)

Section 156.505 sets forth definitions for terms that are used throughout subpart F. Many of the definitions presented in § 156.505 are taken directly from the Affordable Care Act, but new definitions were created when necessary. All definitions proposed are intended to apply only to subpart F.

Several of the terms used in subpart F are defined elsewhere in Parts 155 and 156, which have been proposed previously (76 FR 41866). The terms ''individual market,'' ''small group market,'' ''SHOP,'' and ''Exchange'' are defined in § 155.20. ''Individual market'' is defined as the market for health insurance coverage offered to

individuals other than in connection with a group health plan. ''Small group market'' is defined as the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a small employer. ''SHOP'' is defined as a Small Business Health Options Program operated by an Exchange through which a qualified employer can provide its employees and their dependents with access to one or more QHPs. ''Exchange'' is defined as a governmental agency or non-profit entity that meets the applicable requirements of this part and makes QHPs available to qualified individuals and qualified employers. Unless otherwise identified, this term refers to State Exchanges, regional Exchanges, subsidiary Exchanges, and a Federally-facilitated Exchange.

CMS proposes that a ''CO–OP qualified health plan'' means a health plan that has in effect a certification that it meets the standards described in subpart C of part 156, which has been previously proposed (76 FR 41866), except that the plan can be deemed certified by CMS or an entity designated by CMS as described in 156.520(e).

''*Applicant''* is defined as an entity eligible to apply for a loan described in § 156.520.

A ''qualified nonprofit health insurance issuer'' is a loan recipient, which satisfies or can reasonably be expected to satisfy the standards in section 1322(c) of the Affordable Care Act and § 156.515 within the time frames specified in this subpart, until such time as CMS determines the loan recipient does not satisfy or cannot reasonably be expected to satisfy these standards. This ensures that loan recipients can receive the benefits of section 1322(h), addressing the tax exemption for qualified nonprofit health insurance issuers, at the appropriate time, as determined by the Internal Revenue Service. CMS proposes that the term ''consumer operated and oriented plan (CO–OP)'' means a loan recipient that satisfies the standards in section 1322(c) of the Affordable Care Act and § 156.515 within the time frames specified in this subpart. Thus, to be considered a CO–OP, a loan recipient must meet the governance and health plan issuance standards described in § 156.515 within the timeframes established in this subpart. In addition, the loan recipient must comply with State insurance laws and State insurance reforms and ensure that revenues in excess of expenses inure to the benefit of its members in accordance with section 1322(c)(4) of the Affordable Care Act.

We define a ''*nonprofit member corporation''* (also referred to as a ''nonprofit member organization'') as a nonprofit, not-for-profit, public benefit, or similar membership entity organized as appropriate under State law. For the purposes of this subpart, as defined in section 1304(d) of the Affordable Care Act, ''State'' means each of the 50 States and the District of Columbia. CMS proposes that in order for an organization to be eligible for CO–OP loans (and become an ''applicant'') it would first have to meet the definition of a nonprofit member organization.

CMS proposes to adopt the Advisory Board's recommendation to use the terms ''*formation board''* and ''*operational board''* when discussing the governance requirements for a CO–OP. The term ''formation board'' means the initial board of directors of the applicant or loan recipient before it has begun accepting enrollment and conducted an election to the board of directors. ''Operational board'' means the board of directors elected by the members of the CO–OP after it has begun accepting enrollment. A ''member'' is an individual covered under health insurance policies issued by a CO–OP.

Section 1322(c)(2)(A) of the Affordable Care Act prohibits an organization from participating as a ''*qualified nonprofit health insurance issuer''* in the CO–OP program ''if the organization or a related entity (or any predecessor of either) was a health insurance issuer on July 16, 2009.'' Consistent with section 1551 of the Affordable Care Act, we propose that an entity is an ''issuer'' under this subpart if it satisfies the definition in section 2791(b)(2) of the Public Health Service Act: an insurance company, insurance service, or insurance organization (including a health maintenance organization) which is licensed to engage in the business of insurance in a State and which is subject to State law which regulates insurance. Additionally, ''*pre-existing issuer''* means (for the purposes of this subpart) a health insurance issuer that was in existence on July 16, 2009. We seek comments on this definition.

CMS proposes the definition of ''related entity'' to mean an organization that shares common ownership or control with a pre-existing issuer or a trade association whose members consist of pre-existing issuers, *and* satisfies at least one of the following conditions: (1) Retains responsibilities for the services to be provided by the issuer; (2) furnishes services to the issuer's enrollees under an oral or written agreement; or (3) performs some of the issuer's management functions under contract or delegation. Thus, CMS would permit a nonprofit organization that is not an issuer or the representative of an issuer but shares control with an existing issuer to ''sponsor'' or facilitate the creation of a CO–OP if the applicant (and resulting CO–OP) and the existing issuer do not share the same chief executive or any of the board of directors. We seek comment on this interpretation.

''*Sponsor''* is defined as an organization or individual that is involved in the development, creation, or organization of the CO–OP or provides financial support to a CO–OP. We propose that a ''*predecessor''* means any entity that participates in a merger, consolidation, purchase or acquisition of property or stock, corporate separation, or other similar business transaction that results in the formation of the new entity.

Section 1322(b)(1) of the Affordable Care Act directs CMS to award to applicants loans to provide assistance in meeting start-up costs and any State solvency requirements in the States in which the applicant seeks to be licensed to issue CO–OP qualified health plans. ''*Start-up Loan''* means a loan provided by CMS to a loan recipient for costs associated with creating and developing a CO–OP. The term ''*Solvency Loan''* means a loan provided by CMS to a loan recipient in order to meet State solvency and reserve requirements.

C. Eligibility (§ 156.510)

Section 156.510 outlines the minimum standards that an organization must meet to be eligible to receive a loan from the CO–OP program to create a new private consumer-operated insurer.

1. General

In paragraph (a), we propose that the applicant declare its intention to become a CO–OP. Since the loan recipient may not meet all of the conditions to be considered a CO–OP at the time of the application, it is important that the organization intend to meet all of the standards and demonstrate the likelihood of being able to meet such requirements by the time periods established in this subpart before the award is made, especially those related to consumer focus and consumer governance of the organization.

Consistent with the recommendation of the Advisory Board, CMS proposes the applicant have formed a nonprofit

member organization under State law prior to applying for a loan. This means that the new nonprofit member corporation, and not an organization that is sponsoring the creation of a CO–OP, would be the applicant for and recipient of a loan.

2. Exclusions From Eligibility

Paragraph (b) codifies the conditions in section 1322(c)(2) of the Affordable Care Act under which an organization will not be eligible to participate in the CO–OP program. Paragraph (b)(1)(i) codifies that if an organization is a pre-existing issuer, a related entity, or any predecessor of either, it is not eligible for loans under the CO–OP program and therefore, cannot become a CO–OP. In addition, an organization is not eligible for the CO–OP program if the organization or a related entity (or any predecessor of either) is a trade association whose members consist of pre-existing issuers. We seek comment on this interpretation.

Paragraph (b)(1)(ii) codifies that, if an organization is sponsored by a State or local government, any political subdivision thereof, or any instrumentality of such government or political subdivision, it is not eligible to be a CO–OP and cannot apply for a loan under the CO–OP program. CMS considered whether this prohibition should apply to provider organizations that are associated with State university medical centers and concluded that medical centers, physician practices, hospitals, and other organizations that are part of a State university system are instrumentalities of the State. We believe that the prohibition against sponsorship by State or local government, and their political subdivisions and instrumentalities, must also apply to medical centers that are part of State or local governments and to medical practice groups that are created and overseen by a medical center owned by State or local government. This prohibition would not apply to Indian tribes. We invite comment on these interpretations.

As incorporated in section 1551 of the Affordable Care Act, section 2791(b)(2) of the PHS Act defines a ''health insurance issuer'' as ''an insurance company, insurance service, or insurance organization * * * which is licensed to engage in the business of insurance in a State and which is subject to State law which regulates insurance (within the meaning of section 514(b)(2) of the Employee Retirement Income Security Act of 1974).'' CMS believes that the following types of entities are examples of organizations that are not ''issuers'' and would be eligible to sponsor applicants for loans under the CO–OP program provided that they otherwise meet the requirements for eligibility:

(1) A prospective applicant not licensed by its State as a health insurance issuer on July 16, 2009, but which has subsequently achieved a State license,

(2) Self-funded and Taft-Hartley group health plans, and

(3) Church plans that were not licensed issuers on July 16, 2009, and

(4) Three-share or multi-share programs not licensed by their State insurance regulator.

CMS invites comment on how these organizations and others like them would sponsor an applicant.

Taking into account comments received on the RFC and the recommendations of the Advisory Board, in paragraph (b)(2)(i) CMS proposes that a nonprofit organization that is not an issuer but that currently sponsors an issuer would remain eligible to sponsor an applicant for a CO–OP loan in certain circumstances. Specifically a nonprofit non-issuer organization that currently sponsors a pre-existing issuer and meets other eligibility parameters may sponsor an applicant for a CO–OP loan provided that the pre-existing issuer does not share any of the board or the same chief executive with the applicant. We seek comment on this interpretation.

In paragraph (b)(2)(ii), we are further proposing that an organization that has purchased assets from a preexisting issuer in an arm's-length transaction where neither party was in a position to exert undue influence on the other is eligible to apply for a CO–OP loan. Therefore, an organization is eligible for CO–OP loans if it contracts for services, including health provider network access, premium billing, and case management from a health insurance issuer that existed on July 16, 2009, as long as the existing issuer has no control over the new private nonprofit issuer. Conversely, an applicant and a pre-existing issuer could have common control by a non-issuer organization. The applicant and pre-existing issuer would not be related entities unless the pre-existing issuer also provided the CO–OP's services or management functions.

D. CO–OP Standards (§ 156.515)

1. General

A CO–OP must satisfy the standards set forth in all statutory, regulatory, or other requirements as applicable. CMS proposes additional standards that a CO–OP must meet in § 156.515, many of which are recommendations made by the Advisory Board in the final report dated April 15, 2011. We invite comment on these proposed standards, which are set forth below.

2. Governance Requirements

In response to the RFC, provider organizations submitted comments that suggested that providers may be in the best position to sponsor CO–OPs and encouraged CMS to impose no additional standards related to governance beyond those in the statute. In contrast, other commenters suggested that CMS set specific standards for the composition of the governing body, such as those to avoid conflicts and to encourage diverse representation on governing bodies that are representative of the local population. Other commenters expressed concern that in some markets providers could create a CO–OP and control pricing in the market.

Section 1322(c)(3)(C) of the Affordable Care Act directs the Secretary to promulgate regulations requiring the organization to operate with a strong consumer focus, including timeliness, responsiveness, and accountability to members. Pursuant to this authority and taking into account the comments, CMS proposes additional governance requirements in paragraph (b). These proposed standards reflect the recommendations of the Advisory Board.

Paragraph (b)(1) proposes that a CO–OP implement policies and procedures to foster and ensure member control of the organization. Section 1322(c)(3) of the Affordable Care Act states that the governance of the organization be subject to a majority vote of its members. Paragraph (b)(1)(i) proposes that the organization be governed by an operational board with each of its directors elected by a majority vote of its members. In paragraph (b)(1)(ii), we propose that every member of the CO–OP be eligible to vote for each director of the CO–OP during the elections described in (b)(1)(iv). In paragraph (b)(1)(iii), we propose that each member of the organization have one vote in the elections of directors.

Paragraph (b)(1)(iv) proposes that the first election of the operational board of directors occur no later than one year after the effective date on which the CO–OP provides coverage to its first member. The Advisory Board recommended that this election should take place within the first year after enrollment begins or when a certain designated membership level is reached, but should occur no later than two years after the organization enrolls its first

member, recognizing that a certain level of membership is necessary for meaningful elections. CMS is concerned that the Advisory Board's recommendation of an election date of the start-up period plus two years after enrollment will delay the introduction of consumer governance beyond a point where it can have an impact on the strategic direction of the CO–OP. We do not believe that holding an election one year after coverage begins will burden the formation board or CO–OP operations since the formation board will have the full start-up period plus one year to plan for this transition. We solicit comments on the proposed timeline.

Paragraph (b)(1)(v) proposes that the elections for the board of directors of the organization be contested and that there be more candidates for open positions on the board than there are positions. We are not specifying the mechanism by which the CO–OP will achieve this standard, but we believe that the CO–OP's bylaws should address this standard, most likely by creating a nominating committee that will ensure that this standard is met. This standard will help ensure that consumer members of the organization have a choice of candidates for the board of directors, provide an opportunity for a change in directors, and help prevent a group of directors from exerting disproportionate control over the organization. CMS believes that the operation of contested elections will provide safeguards against the long-term entrenchment or undue influence of any individual director while protecting the members' choice of directors.

Consistent with the recommendations of the Advisory Board and commenters to the RFC, paragraph (b)(1)(vi) proposes that a majority of the voting directors must be members of the organization. While all directors must be elected by the members, a CO–OP may want to reserve positions for directors who have certain types of expertise that are essential to the governance of the organization, such as providers or individuals with experience in health care operations or finance. CMS recognizes that it may not be possible to find members of the CO–OP with the desired expertise who are willing to serve as directors. The purpose of this provision is to recognize the need to allow for directors who are not members, but to ensure that members who are consumers of the services of the organization are the majority of the board of directors and that the governance of the organization is accountable to consumers.

Standards for the operational board of directors, consistent with the recommendations of the Advisory Board are included in (b)(2). Paragraph (b)(2)(i) specifies that each director must meet ethical, conflict-of-interest, and disclosure standards. Specifically, each director must act in the sole interest of the CO–OP and its members, avoid self-dealing, and act prudently and consistently with the terms of the CO–OP's governance documents and applicable State and Federal law.

Paragraph (b)(2)(ii) specifies that each voting director has only one vote on matters before the board. This standard also recognizes that a CO–OP may choose to have directors who provide expertise but do not vote. Non-voting directors must bring specific expertise or be members of the management team of the CO–OP, whose participation in the board of directors is considered essential.

Paragraph (b)(2)(iii) acknowledges that positions on the board of directors may be designated for individuals with certain types of expertise or experience. The type of expertise that is needed may vary over time and the CO–OP may choose to enlist candidates for the board with certain types of expertise through its nominating process.

Paragraph (b)(2)(iv) specifies that positions on the board that are designated for individuals with specialized expertise, experience, or affiliation (for example, providers, employers, labor representatives) cannot constitute a majority of the operational board even if the individuals serving in designated seats are members of the CO–OP. This standard should be addressed in the bylaws of the CO–OP, in the conflict of interest standard for board members, and in the nominating procedures of the CO–OP.

Paragraph (b)(2)(v) codifies the limitation in section 1322(e) of the Affordable Care Act that no representative of any Federal, State or local government (or of any political subdivision or instrumentality thereof) and no representative of any organization described in § 156.510(b)(i) may serve on the board of directors.

Paragraph (b)(3) codifies the provision that an organization must have governing documents that incorporate ethics and conflict of interest standards protecting against insurance industry involvement and interference. At a minimum, the standards must establish procedures for identifying potential conflicts of interest and addressing any violation of the standards.

Paragraph (b)(4) codifies the provision that the CO–OP must operate with a strong consumer focus, including timeliness, responsiveness, and accountability to members. Finally, the CO–OP must demonstrate financial viability and the ability to meet all other statutory, legal, or other requirements.

3. Requirements to Issue Health Plans and Become a CO–OP

In paragraph (c)(1), CMS codifies section 1322(c)(1)(B) of the Affordable Care Act that provides that substantially all of the activities of the CO–OP consist of the issuance of CO–OP qualified health plans in the individual and small group markets in each State in which it is licensed to issue such plans. CMS proposes that a CO–OP will satisfy this standard if at least two-thirds of the contracts for health insurance coverage issued by a CO–OP are CO–OP qualified health plans offered in the individual and small group markets in the States in which the CO–OP operates. An organization must continually meet this requirement to be considered a CO–OP. Members of the Advisory Board noted that State insurance regulations generally refer to the contracts for insurance, not the number of lives covered under each contract, when referring to policy issuance. The Advisory Board therefore recommended that: the interpretation of ''substantially all'' refer to contracts issued; the proportion of contracts that must meet the ''substantially all'' test be interpreted to provide CO–OPs maximum flexibility; and CO–OPs be allowed to meet that standard over time to build enrollment gradually in the individual and small group market. Consistent with the Advisory Board recommendations on this issue and public comment received in response to the RFC, CMS interprets the statute to mean that each insurance policy or contract that an issuer sells constitutes a single activity. We solicit comments on whether two-third is the appropriate threshold for this standard.

This proposed standard would allow providers wishing to sponsor CO–OPs to enroll their own employees in the CO–OP and thereby encourage provider participation. It would also permit CO–OPs to participate in Medicaid and Children's Health Insurance Program (CHIP), which would enable individuals and families to remain with the same health insurance issuer and providers if they move between the Exchange and these programs.

In paragraph (c)(2), CMS proposes that a CO–OP applicant receiving a Start-up Loan or Solvency Loan offer at least one CO–OP qualified health plan at both the silver and gold benefit levels, as defined in section 1302(d) of the Affordable Care Act, in every individual

market Exchange that serves the geographic market in which it is licensed and intends to provide health care coverage (market area). In addition, CMS proposes that if a CO–OP chooses to offer coverage in the small group market outside the Exchange, a CO–OP must commit to offering at least one CO–OP qualified health plan at both the silver and gold benefit levels in the SHOP of any market area where the CO–OP is licensed. Note that it is a choice for a CO–OP to offer coverage in the small group market, but if it does so, it must also offer coverage through SHOP to prevent adverse selection against SHOP. These standards are consistent with section 1301 of the Affordable Care Act providing that health insurance issuers that participate in the Exchanges offer qualified health plans at both the silver and gold benefit levels.

In paragraph (c)(3) CMS proposes that within the earlier of thirty-six months following the initial drawdown of a Start-up Loan or six months following the initial drawdown of the Solvency Loan, a loan recipient be licensed in a State and offer at least one CO–OP qualified health plan at the silver and gold benefit levels (as defined in section 1302(d) of the Affordable Care Act) in an individual market Exchange and, if offering a health plan in the small group market, in a SHOP. Thus, the loan recipient must satisfy the requirements of title XXVII of the Public Health Service Act applicable to health insurance coverage in the individual market and small group market, if applicable and comply with all standards generally applicable to qualified health plan issuers. To continue offering CO–OP qualified health plans in the Exchanges, a CO–OP must continue to meet these standards.

Due to concerns regarding the ability of a CO–OP to establish sufficient enrollment to make its health plans viable, CMS proposes that when offering a CO–OP qualified health plan in an Exchange for the first time, loan recipients may only begin to offer health plans and accept enrollment during an open enrollment period for the applicable Exchange. We seek comment on this proposal.

In paragraph (d), CMS proposes that a loan recipient must satisfy the requirements of section 1322(c) of the Affordable Care Act and § 156.515 and become a CO–OP within fifty-four months following the first drawdown of a Start-up Loan or eighteen months following the initial drawdown of a Solvency Loan.

These provisions will ensure that loan recipients actively work toward becoming a CO–OP that offers CO–OP qualified health plans in the Exchanges. Commenters to the RFC indicated that it could take from 6 months to 3 years for a new CO–OP to become operational and begin accepting enrollment, with most commenters stating that 18 to 24 months would be needed to become operational. CMS believes that the proposed timeframes provide sufficient time for a loan recipient to offer CO–OP qualified health plans in the Exchanges and become a new CO–OP that meets all of the governance requirements of the CO–OP program. We request comment on these proposed standards.

E. Loan Terms (§ 156.520)

1. Overview of Loans

Paragraph (a)(1), proposes that organizations that meet eligibility standards according to § 156.510 can apply for Start-up Loans and Solvency Loans (pursuant to a separate CO–OP program Funding Opportunity Announcement (FOA)). Organizations may apply for Start-up Loans to assist with start-up costs associated with establishing a CO–OP. In addition, CMS proposes that organizations that meet the eligibility standards may apply for Solvency Loans to assist in meeting the solvency requirements of States in which the applicant seeks to be licensed to issue CO–OP qualified health plans.

Section § 156.520 outlines the terms of the loans awarded under the CO–OP program. Other than the 5-year and 15-year repayment periods, the statute leaves the specific terms of the loans to CMS's discretion but requires that CMS take into consideration State solvency requirements. Accordingly, CMS proposes loan terms that are consistent with the goals of the CO–OP program, most likely to encourage successful CO–OPs, and protect the Federal investment.

The Advisory Board strongly recommended that CMS begin awarding loans in late 2011 or early 2012 to provide sufficient time for CO–OPs to become operational and accept enrollment during the first Exchange open enrollment period to compete for membership and gain the level of enrollment needed to be viable. Commenters to the RFC generally agreed that it is important for CMS to provide startup funding to CO–OPs as soon as possible. Accordingly, we intend to begin awarding CO–OP loans in this timeframe.

As a condition of licensure as a health insurer, State insurance departments require that an insurer maintain an amount of capital that is consistent with its size and risk profile. This measure of reserve is called risk-based capital (RBC). State law establishes a variety of required regulatory actions if an insurer's RBC falls below established levels or percent of RBC. These regulatory interventions can range from a corrective action plan to liquidation of the insurer if it is insolvent. Solvency and the financial health of insurers is historically a State-regulated function.

Solvency Loans are intended to help loan recipients meet the reserve requirements, solvency regulations, and requisite surplus note arrangements in each State. Since Solvency Loans must be repaid to the Federal government within 15 years, the Advisory Board expressed a concern that they will be treated by States as debt rather than capital that satisfies State solvency and reserve requirements.

A loan is considered a liability and typically would not assist an organization in meeting solvency requirements, since the liability would have to be subtracted from the calculation of reserves in order to determine the net protection afforded to enrollees. In order to assist CO–OPs in meeting State solvency requirements, the loans will be structured so that premiums would go to pay claims and meet cash reserve requirements before repayment to CMS. The goal of this provision is to satisfy the reserve requirements of the individual insurance department in the States in which each CO–OP seeks licensure. The Advisory Board proposed that CO–OPs discuss the appropriate mechanisms with their insurance regulators for structuring the loans to meet reserve requirements and include a description of those mechanisms in their applications so that loan and repayment terms for that applicant conform to the State's requirements.

CMS proposes in § 156.520(a)(3) to structure Solvency Loans to each loan recipient in a manner that meets State reserve and solvency requirements so that the loan recipient can fund its required capital reserves. This ensures that they are recognized as contributing to State reserve and solvency requirements in the States in which the applicant intends to offer CO–OP qualified health plans. We request comment on this provision.

2. Repayment Period

Section 1322(b)(3) of the Affordable Care Act states that loans awarded must be repaid within 5 years and 15 years respectively, taking into consideration any appropriate State reserve requirements, solvency regulations, and requisite surplus note arrangements that must be constructed in a State. This standard is codified in § 156.520(b).

Loan recipients must make loan payments consistent with the repayment schedule approved by CMS and agreed to by the loan recipient until the loans have been paid in full. Recognizing that it would be difficult for a loan recipient to begin repaying the loans before it has enrolled members and received premiums, the Advisory Board recommended that loan repayment begin after the loan recipient has begun receiving enrollment. Commenters to the RFC generally recommended repayment schedules for loans that are flexible. Most commenters indicated that preventing the failure of a CO–OP should take priority over repayment because insolvency of a CO–OP would harm its members and create disruption in insurance markets.

CMS agrees with the commenters and believes that a flexible repayment approach would promote the growth of CO–OPs, serve the interests of the CO–OP members and the public, and enhance the likelihood of full repayment. Flexibility in the repayment schedule helps address the diversity in each CO–OP's local market conditions, projected member risk profiles, business strategy, and projected enrollment size. CMS proposes to permit individualized repayment schedules to be submitted with the application with features such as a grace period, graduated repayments, or balloon payments at the end of the repayment period.

The Advisory Board recommended an enhanced oversight process for cases where a loan recipient is not meeting the terms and conditions of its loan but where CMS has concluded that discontinuing funding is not in the best interest of the members, the public, or the government. Consistent with the Advisory Board's recommendation, CMS may execute a loan modification or workout when a loan recipient is having difficulty making loan repayments. If a loan recipient is unable to (1) make repayments or meet other conditions of the loan without adversely affecting coverage stability, member control, quality of care, or the public interest generally or (2) meet State reserve and solvency requirements, CMS would have the option to execute a loan modification or workout.

3. Interest Rates

In § 156.520(c), CMS proposes that loan recipients pay an interest rate benchmarked to the average interest rate on marketable Treasury securities of similar maturity. These interest rates are tied to prevailing market conditions while providing low cost loans that are consistent with the statute's direction to foster the development of viable private nonprofit CO–OPs. CMS is considering reductions to the benchmarked rate for Start-Up Loans and Solvency Loans to make it easier for new CO–OPs to repay their loans.

Section 1322(b)(2)(C)(iii) of the Affordable Care Act states that if CMS determines that a loan recipient has failed to meet any of its contractual obligations, or has used Federal funds in a prohibited or improper manner, the loan recipient must repay to CMS 110 percent of the aggregate amount of loans received under this section, plus interest. This provision is codified in § 156.520(c) so that if a loan recipient's loan agreement is terminated by CMS, the loan recipient would be charged the statutory penalty and an interest rate equal to the average interest rate on marketable Treasury securities of similar maturity. We request public comment on the proposed interest rates and the structure of the debt instrument.

4. Failure to Pay

In § 156.520(d), CMS proposes to use any and all remedies available to it under law to collect loan payments or penalty payments if a loan recipient fails to make payments consistent with the repayment schedule in its loan agreement or in a loan modification or workout.

5. Deeming of CO–OP Qualified Health Plans

In § 156.520(e) we codify the ''deeming'' provisions of section 1301(a)(2) of the Affordable Care Act. To be deemed certified to participate in an Exchange, we propose that a loan recipient must be in compliance with the terms of the CO–OP program, the Federal standards for CO–OP qualified health plans set forth pursuant to section 1311(c) of the Affordable Care Act and State standards. CMS or an entity designated by CMS will make a determination regarding whether or not a loan recipient meets these standards based on evidence provided by the loan recipient. CMS or its designee will notify the Exchange in which the loan recipient proposes to operate that the loan recipient is deemed certified to participate. Similarly, if a loan recipient loses its deemed status for any reason, CMS or its designee will provide notice to the applicable Exchanges.

A loan recipient that is deemed certified to participate in the Exchange would be exempt from the certification procedures for each applicable Exchange. However, the loan recipient must still meet any standards established by CMS for all qualified health plans participating in an Exchange, along with all State requirements in the case where a State is operating the Exchange.

6. Conversions

The Advisory Board expressed a concern about the potential for successful CO–OPs to become targets for conversion to for-profit, non-consumer operated entities. Such an outcome could reduce consumer control, limit choice, and weaken competition in the insurance marketplace. Accordingly, the Advisory Board recommended imposing conditions on conversions that would create strong disincentives for a company to acquire a CO–OP and for a CO–OP to pursue such offers. Because allowing conversions to a for-profit or non-consumer operated entity would be contrary to the goals of the CO–OP program, CMS proposes to prohibit such conversions. This prohibition on conversions and sales to for-profit or non-consumer operated entities would ensure that loans awarded under this program are used to sustain program goals over time.

CMS recognizes the potential for changes in CO–OP governance in circumstances other than conversions and sales to for-profit or non-consumer-operated entities. Since the goals of the CO–OP program are to make available new consumer-governed private nonprofit health plans and expand competition in the Exchanges, CMS proposes to prohibit any transaction by a CO–OP that would result in a change to a governance structure that does not meet the standards in § 156.515 or any other program standards. We request comment on these prohibitions.

III. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 60-day notice in the **Federal Register** and solicit public comment before an information collection request is submitted to the Office of Management and Budget (OMB) for review and approval. We will solicit comments on the information collection request in association with the implementation of the CO–OP program (for example, application, reporting) in one or more future 60-day notices.

V. Regulatory Impact Analysis (RIA)

A. Introduction

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic,

environmental, public health and safety effects, distributive impacts, and equity). An RIA must be prepared for rules with economically significant effects ($100 million or more in any 1 year). This proposed rule is economically significant. Accordingly, the Office of Management and Budget has reviewed this proposed rule.

B. Statement of Need, Health Insurance Markets, and CO–OP Plans

The Affordable Care Act established the Consumer Operated and Oriented Plan (CO–OP) program. Section 1322(b)(3) of the Affordable Care Act requires CMS to promulgate regulations to implement this program. The purpose of this program is to create a new CO–OP in every State in order to expand the number of qualified health plans available in the Exchanges with a focus on integrated care and greater plan accountability.

Only a few States offer insurance choices sponsored and managed by entities primarily focused on meeting the health insurance needs and preferences of consumers, as determined directly by consumers or their elected representatives. Currently, we believe that there are four issuers in the country that meet this standard, located in the States of Washington, Idaho, Minnesota, and Wisconsin. While these issuers cover in excess of one million lives, their market share is only about one percent of private insurance coverage.

Congress has provided budget authority of $3.8 billion to assist sponsoring organizations in creating such plans and to do so with enough capital and reserves to become licensed and ultimately effective competitors in State insurance markets. These funds will enable CO–OPs to use Federal government loans (''Solvency Loans'') to meet the requirements for risk-based capital that State insurance commissions impose on health plans to ensure that they will be able to finance the services they have contractually promised their enrollees.

The Affordable Care Act, as implemented through this regulation, prohibits issuers that existed prior to July 16, 2009 from participating in the CO–OP program but allows CO–OPs to use experienced managers and health care organizations to manage the functions they have to perform in providing health insurance. Further, as indicated throughout the preamble to this proposed rule, the CO–OP Advisory Board in its advice to the Secretary, and the Department in its proposed provisions, have consistently favored provisions that would give CO–OP flexibility, within the boundaries set by the statute, in setting up and operating these plans.

CO–OPs may not, however, enter the program unless their activities are limited primarily to issuing plans in the individual and small group markets. CO–OPs will therefore face the problem of being either brand new organizations or existing organizations facing a major change in purpose.

C. Anticipated Federal Costs

As previously explained, Congress has provided $3.8 billion to assist sponsoring organizations in creating such plans and to do so with enough capital and reserves to become licensed and ultimately effective competitors in State insurance markets.[1] The capital requirements for CO–OPs would be financed, in part, by member premiums and in part by the $3.8 billion dollars available for loans over the next five years. The net Federal costs of these loans to CO–OPs are ''transfers.'' The net transfer costs resulting from default and loss of interest over the relevant 5 year (Start-up Loan) and 15 year (Solvency Loan) periods are estimated later in this analysis, in Table 1. We estimate that 65 percent of the Solvency Loans and 60 percent of the Start-up Loans will be repaid. Our estimates use one percent below the current yields for 5-year U.S. Treasury bonds as the repayment interest rate on Start-up Loans and two percent below the current yields for longer term U.S. Treasury Bonds as the repayment rate for the Solvency Loans.

D. Anticipated Benefits

CO–OPs also offer a unique opportunity to foster and spread emerging models of integrated delivery systems, both to improve health outcomes and to lower health costs (see, for example, testimony of Sara Collins before the Advisory Committee, *The Consumer Operated and Oriented Plan (CO–OP) Program Under the Affordable Care Act: Potential and Options for Spreading Mission-Driven Integrated Delivery Systems,* at *http://www.commonwealthfund.org/~/media/Files/Publications/Testimony/2011/Jan/Collins_CoOp%20testimony_11311.pdf).* CO–OPs can adopt new models and new arrangements that are more patient-centered than the current fragmented delivery system. Improved delivery systems may provide better health outcomes due to coordinated care, better chronic disease management, and improved quality of care.

In addition, by adding competition in numerous local and State markets, CO–OPs have the potential to promote efficiency, reduce premiums or premium growth, and improve service and benefits to enrollees. By their nature, traditional cooperatives, on which the CO–OP program is modeled, focus on responsiveness to their members and accountability to member needs, which may create flexibility to reduce administrative costs. Direct savings could be substantial after the initial start-up period given the magnitude of the total spending that may be involved. Resulting attempts to regain market share by traditional insurance issuers competing with CO–OPs could lead to system-wide savings across millions of enrollees.

E. Alternatives Considered

Throughout this proposed rule we have presented and analyzed alternatives. The program is largely defined by the statute, but in this proposed rule, we have sought to identify options that would best enable newly formed CO–OPs to offer CO–OP qualified health plans. We welcome comments on any other alternatives that would improve the proposed rule and the likelihood of program success.

The most important alternatives to our proposed standards would be to impose either a higher or lower interest repayment on loans. Among the thousands of Federal programs providing financial assistance, the great majority make grants that are not repayable. The Federal government also provides financial assistance through loan programs. Borrower interest rates, in some cases, are higher than Treasury rates, while in other cases rates are subsidized by the Government (see the estimates in the Federal Credit Supplement volume of the Budget of the United States Government for FY 2012, at *http://www.gpoaccess.gov/usbudget/fy12/cr_supp.html*).

There is also a tradeoff between the amount of a loan subsidy and the likely default rate. For example, if a 1 percent increase in the interest rate were to increase the likelihood of total default by 1 percent or more, the net effect would be to increase Federal costs. In the CO–OP program, substantially higher interest rates could threaten required solvency reserves. We cannot predict quantitatively the effects of

[1] We note that these capital requirements are not ''cost'' for the purpose of calculating the benefits and costs of this Federal program. Costs, in the context of this program, are the resources spent on applying for and complying with the terms of the loans. As noted above, we will solicit comments on the information collection requests associated with the implementation of the CO–OP program (for example, application, reporting) in one or more future 60-day notices.

interest charges on the willingness of organizations to sponsor CO–OPs, but substantially higher interest charges would clearly reduce the likelihood of CO–OPs being created in as many States. Higher interest charges could also reduce the ability of CO–OPs to expand and correspondingly reduce the benefits of the program.

F. Accounting Statement

As required by OMB Circular A–4, we have prepared an accounting statement. The transfer costs shown are the net costs resulting from default and loss of interest over the relevant 5 year (Start-up Loan) and 15 year (Solvency Loan) periods. We have estimated that $600 million would be used for Start-up Loans and $3,200 million would be used for Solvency Loans. As previously presented, for purposes of this calculation our primary estimate is that 65 percent of the Solvency Loans and 60 percent of the Start-up Loans are repaid. We have used a low-cost estimate that assumes 80 percent repayment of all loans and a high-cost estimate that assumes 50 percent repayment of all loans. Our estimates use one percent below the current yields for 5-year U.S. Treasury bonds as the repayment interest rate on Start-up loans and two percent below the current yields for the average of 10-year and 20-year U.S. Treasury Bonds as the repayment rate for the Solvency Loans (see *http://www.treasury.gov/resource-center/data-chart-center/interest-rates/Pages/TextView.aspx?data=yield*).

TABLE 1—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED COSTS AND SAVINGS

[$ in millions]

Category	Primary estimate	Low estimate	High estimate	Units		
				Year dollars	Discount rate (%)	Period covered
Benefits						
Qualitative: New CO–OP enrollees served may experience better health outcomes. There are also potential cost savings system-wide from competitive effects on other health care plans. Net benefits will depend on the extent to which CO–OP plans augment or substitute for other health care insurance and services.						
Costs						
Qualitative: Costs include administrative burdens associated with applying for and complying with the terms of the loans.						
Transfers						
Federal Government Costs	$210 million $110 million	$190 million $80 million	$230 million $140 million	2012 2012	7 3	2012–31 2012–31

VI. Other Requirements for Analysis of Economic Effects

The Regulatory Flexibility Act (RFA) requires agencies to determine whether proposed rules would have a ''significant economic impact on a substantial number of small entities'' and, if so, to prepare a Regulatory Flexibility Analysis to identify options that could mitigate the impact of the proposed regulation on small businesses.

All CO–OPs established under the program will be private nonprofit organizations and hence qualify as small entities under the RFA. CMS interprets the requirement as applying only to regulations with negative impacts, but routinely prepares a voluntary Regulatory Flexibility Analysis for regulations with significant positive impacts.

The positive economic impacts of the program on CO–OPs will clearly be ''significant,'' particularly in the effects on thousands of small businesses that are likely to purchase insurance through the Exchanges and would benefit from the lower premium costs that CO–OPs will likely create. Moreover, small businesses will have the opportunity to create consortia to help sponsor CO–OPs and may actively pursue these savings. In the light of the benefits to these small entities, the Department has prepared a voluntary Regulatory Flexibility Analysis. The preceding economic analysis, together with the remainder of this preamble, constitutes that analysis.

Section 1102(b) of the Social Security Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. We do not believe a regulatory impact analysis is required here because this proposed rule would not have a direct effect on small rural hospitals or other providers.

Section 202 of the Unfunded Mandates Reform Act of 1995 requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates on State, local, or tribal governments in the aggregate, or on the private sector, require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. This proposed rule would impose no such mandates. Accordingly, no analysis under UMRA is required.

Executive Order 13132 on Federalism establishes requirements that an agency must meet when a proposed rule imposes substantial costs on State and local governments, preempts State law, or otherwise has Federalism implications. This proposed rule does not trigger these requirements.

List of Subjects in 45 CFR Part 156

Administrative practice and procedure, Advertising, Advisory committees, Brokers, Conflict of interest, Consumer protection, Grant programs—health, Grants administration, Health care, Health insurance, Health maintenance organization (HMO), Health records, Hospitals, Indians, Individuals with disabilities, Loan programs—health, Organization and functions (Government agencies), Medicaid, Public assistance programs, Reporting and recordkeeping requirements, Safety, State and local governments, Sunshine Act, Technical Assistance, Women, and Youth.

For the reasons set forth in the preamble, the Department of Health and Human Services proposes to further amend 45 CFR part 156, as proposed to

be added at 76 FR 41866, July 15, 2011, as set forth below:

PART 156—HEALTH PLAN REQUIREMENTS UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT, INCLUDING REQUIREMENTS RELATED TO EXCHANGES

1. The authority citation for part 156 continues to read as follows:

Authority: Title I of the Affordable Care Act, Sections 1301–1304, 1311–1312, 1321, 1322, 1324, 1334, 1342–1343, and 1401–1402.

2. Subpart F is added to read as follows:

Subpart F—Consumer Operated and Oriented Plan Program

Sec.
156.500 Basis and scope.
156.505 Definitions.
156.510 Eligibility.
156.515 CO–OP minimum standards.
156.520 Loan terms.

Subpart F—Consumer Operated and Oriented Plan Program

§ 156.500 Basis and scope.

This subpart implements section 1322 of the Affordable Care Act by establishing the Consumer Operated and Oriented Plan (CO–OP) program to foster the creation of new consumer-governed, private, nonprofit health insurance issuers, known as ''CO–OPs.'' Under this program, loans are awarded to encourage the development of CO–OPs. Applicants that meet the eligibility standards of the CO–OP program may apply to receive loans to help fund start-up costs and meet the solvency requirements of States in which the applicant seeks to be licensed to issue CO–OP qualified health plans. This subpart sets forth the governance requirements for the CO–OP program and the terms for loans awarded under the CO–OP program.

§ 156.505 Definitions.

The following definitions apply to this subpart:

Applicant means an entity eligible to apply for a loan described in § 156.520 of this subpart.

Consumer operated and oriented plan (CO–OP) means a loan recipient that satisfies the standards in section 1322(c) of the Affordable Care Act and § 156.515 of this subpart within the timeframes specified in this subpart.

CO–OP qualified health plan means a health plan that has in effect a certification that it meets the standards described in subpart C of part 156, except that the plan can be deemed certified by CMS or an entity designated by CMS as described in § 156.520(e).

Exchange has the meaning given to the term in proposed § 155.20.

Formation board means the initial board of directors of the applicant or loan recipient before it has begun accepting enrollment and had an election by the members of the organization to the board of directors.

Individual market has the meaning given to the term in proposed § 155.20.

Issuer means an insurance company, insurance service, or insurance organization (including a health maintenance organization) which is licensed to engage in the business of insurance in a State and which is subject to State law which regulates insurance.

Member means an individual covered under health insurance policies issued by a loan recipient.

Nonprofit member organization or *nonprofit member corporation* means a nonprofit, not-for-profit, public benefit, or similar membership entity organized as appropriate under State law.

Operational board means the board of directors elected by the members of the loan recipient after it has begun accepting enrollment.

Predecessor, with respect to a new entity, means any entity that participates in a merger, consolidation, purchase or acquisition of property or stock, corporate separation, or other similar business transaction that results in the formation of the new entity.

Pre-existing issuer means a health insurance issuer that was in existence on July 16, 2009.

Qualified nonprofit health insurance issuer means a loan recipient, which satisfies or can reasonably be expected to satisfy the standards in section 1322(c) of the Affordable Care Act and § 156.515 of this subpart within the time frames specified in this subpart, until such time as CMS determines the loan recipient does not satisfy or cannot reasonably be expected to satisfy these standards.

Related entity means an entity that shares common ownership or control with a pre-existing issuer or a trade association whose members consist of pre-existing issuers, and satisfies at least one of the following conditions:

(1) Retains responsibilities for the services to be provided by the issuer;

(2) Furnishes services to the issuer's enrollees under an oral or written agreement; or

(3) Performs some of the issuer's management functions under contract or delegation.

SHOP has the meaning given to the term in proposed § 155.20.

Small group market has the meaning given to the term in proposed § 155.20.

Solvency Loan means a loan provided by CMS to a loan recipient in order to meet State solvency and reserve requirements.

Sponsor means an organization or individual that is involved in the development, creation, or organization of the CO–OP or provides financial support to a CO–OP.

Start-up Loan means a loan provided by CMS to a loan recipient for costs associated with establishing a CO–OP.

State has the meaning given to the term in proposed § 155.20.

§ 156.510 Eligibility.

(a) *General.* In addition to the eligibility standards set forth in the CO–OP program Funding Opportunity Announcement (FOA), to be eligible to apply for and receive a loan under the CO–OP program, an organization must intend to become a CO–OP and be a nonprofit member organization.

(b) *Exclusions from eligibility.* (1) Subject to paragraph (b)(2) of this section, an organization is not eligible to apply for a loan if:

(i) The organization is a pre-existing issuer, a trade association whose members consist of pre-existing issuers, a related entity, or a predecessor of either; or

(ii) A State or local government, any political subdivision thereof, or any instrumentality of such government or political subdivision is a sponsor of the organization.

(2) The exclusion of pre-existing issuers in paragraph (b)(1)(i) of this section does not exclude from eligibility an applicant that:

(i) Has as a sponsor a nonprofit organization that is not an issuer or a trade association whose members consist of issuers and that also sponsors a pre-existing issuer, provided that the pre-existing issuer does not share any of its board or the same chief executive with the applicant; or

(ii) Has purchased assets from a preexisting issuer provided that it is an arm's-length transaction where neither party was in a position to exert undue influence on the other.

§ 156.515 CO–OP standards.

(a) *General.* A CO–OP must satisfy the standards in this section in addition to all other statutory, regulatory, or other requirements.

(b) *Governance requirements.* A CO–OP must meet the following governance requirements:

(1) *Member control.* A CO–OP must implement policies and procedures to foster and ensure member control of the

organization. Accordingly, a CO–OP must meet the following the requirements:

(i) The CO–OP must be governed by an operational board with all of its directors elected by a majority vote of the CO–OP's members;

(ii) All members must be eligible to vote for each director on the organization's operational board;

(iii) Each member of the organization must have one vote in the elections of the directors of the organization's operational board;

(iv) Elections of the directors on the organization's operational board must occur no later than one year after the effective date on which the organization provides coverage to its first member;

(v) Elections of the directors on the organization's operational board must be contested so that the number of candidates for vacant positions on the operational board exceeds the number of vacant positions; and

(vi) The majority of the voting directors on the operational board must be members of the organization.

(2) *Standards for board of directors.* The operational board for a CO–OP must meet the following standards:

(i) Each director must meet ethical, conflict-of-interest, and disclosure standards including that each director act in the sole interest of the CO–OP;

(ii) Each director has one vote unless he or she is a non-voting director;

(iii) Positions on the board of directors may be designated for individuals with specialized expertise, experience, or affiliation (for example, providers, employers, and unions);

(iv) Positions on the operational board that are designated for individuals with specialized expertise, experience, or affiliation cannot constitute a majority of the operational board even if the individuals in those positions are members of the CO–OP. This provision does not prevent any individual from seeking election to the operational board based on being a member of the CO–OP; and

(v) Limitation on government and issuer participation. No representative of any Federal, State or local government (or of any political subdivision or instrumentality thereof) and no representative of any organization described in § 156.510(b)(1)(i) of this subpart may serve on the CO–OP's formation board or operational board.

(3) *Ethics and conflict of interest protections.* The CO–OP must have governing documents that incorporate ethics, conflict of interest, and disclosure standards. The standards must protect against insurance industry involvement and interference. In addition, the standards must ensure that each director acts in the sole interest of the CO–OP and its members, avoids self dealing, and acts prudently and consistently with the terms of the CO–OP's governance documents and applicable State and Federal law. At a minimum, these standards must include:

(i) A mechanism to identify potential ethical or other conflicts of interest;

(ii) A duty on the CO–OP's executive officers and directors to disclose all potential conflicts of interest;

(iii) A process to determine the extent to which a conflict exists;

(iv) A process to address any conflict of interest; and

(v) A process to be followed in the event a director or executive officer of the CO–OP violates these standards.

(4) *Consumer focus.* The CO–OP must operate with a strong consumer focus, including timeliness, responsiveness, and accountability to members.

(c) *Standards for health plan issuance.* A CO–OP must meet several standards for the issuance of health plans in the individual and small group market.

(1) At least two-thirds of the policies or contracts for health insurance coverage issued by a CO–OP in each State in which it is licensed must be CO–OP qualified health plans offered in the individual and small group markets.

(2) Loan recipients must offer a CO–OP qualified health plan at the silver and gold benefit levels, defined in section 1302(d) of the Affordable Care Act, in every individual market Exchange that serves the geographic regions in which the organization is licensed and intends to provide health care coverage. If offering at least one plan in the small group market, loan recipients must offer a CO–OP qualified health plan at both the silver and gold benefit levels, defined in section 1302(d) of the Affordable Care Act, in each SHOP that serves the geographic regions in which the organization offers coverage in the small group market.

(3) Within the earlier of thirty-six months following the initial drawdown of the Start-up Loan or 6 months following the initial drawdown of the Solvency Loan, loan recipients must be licensed in a State and offer at least one CO–OP qualified health plan at the silver and gold benefit levels, defined in section 1302(d) of the Affordable Care Act, in the individual market Exchanges and if the loan recipient offers coverage in the small group market, at the silver and gold benefit levels, defined in section 1302(d) of the Affordable Care Act, in the SHOPs. Loan recipients may only begin offering plans and accepting enrollment in the Exchanges for new CO–OP qualified health plans during the open enrollment period for each applicable Exchange.

(d) *Requirement to become a CO–OP.* Loan recipients must meet the standards of § 156.515 of this subpart no later than fifty-four months following initial drawdown of the Start-up Loan or eighteen months following the initial drawdown of a Solvency Loan.

§ 156.520 Loan terms.

(a) *Overview of Loans.* (1) Applicants may apply for the following loans under this section: Start-up Loans and Solvency Loans.

(2) All loans awarded under this subpart must be used in a manner that is consistent with the FOA, the loan agreement, and all other statutory, regulatory, or other requirements.

(3) Solvency Loans awarded under this subsection will be structured in a manner that ensures that the loan amount is recognized by State insurance regulators as contributing to the State-determined reserve requirements or other solvency requirements (rather than debt) consistent with the insurance regulations for the States in which the loan recipient will offer a CO–OP qualified health plan.

(b) *Repayment period.* The loan recipient must make loan payments consistent with the approved repayment schedule in the loan agreement until the loan is paid in full consistent with State reserve requirements, solvency regulations, and requisite surplus note arrangements. Subject to their ability to meet State reserve requirements, solvency regulations, or requisite surplus note arrangements, the loan recipient must repay its loans and, if applicable, penalties within the repayment periods in paragraphs (b)(1), (2), or (3) of this section.

(1) The contractual repayment period for Start-up Loans and any associated penalty is five years following each drawdown of loan funds consistent with the terms of the loan agreement.

(2) The contractual repayment period for Solvency Loans and any associated penalty is fifteen years following each drawdown of loan funds consistent with the terms of the loan agreement.

(3) Changes to the loan terms, including the repayment periods, may be executed if CMS determines that the loan recipient is unable to repay the loans as a result of State reserve requirements, solvency regulations, or requisite surplus note arrangements or without compromising coverage stability, member control, quality of care, or market stability. In the case of

a loan modification or workout, the repayment period for loans awarded under this subpart is the repayment period established in the loan modification or workout. The revised terms must meet all other regulatory, statutory, and other requirements.

(c) *Interest rates.* Loan recipients will be charged interest for the loans awarded under this subpart. Interest will be accrued starting from the date of drawdown on the loan amounts that have been drawn down and not yet repaid by the loan recipient. The interest rate will be determined based on the date of award.

(d) *Failure to pay.* Loan recipients that fail to make loan payments consistent with the repayment schedule or loan modification or workout approved by CMS will be subject to any and all remedies available to CMS under law to collect the debt.

(e) *Deeming of CO–OP qualified health plans.* Health plans offered by a loan recipient may be deemed certified as a CO–OP qualified health plan to participate in the Exchanges for up to 10 years following the life of any loan awarded to the loan recipient under this subpart, consistent with section 1301(a)(2) of the Affordable Care Act. An Exchange must recognize a health plan offered by a loan recipient as an eligible participant of the Exchange if it is deemed certified by CMS or an entity designated by CMS. To be deemed as certified to participate in the Exchanges, the loan recipient must comply with the standards for CO–OP qualified health plans set forth pursuant to section 1311(c) of the Affordable Care Act, all State-specific standards established by an Exchange for qualified health plans operating in that Exchange, and the standards of the CO–OP program as set forth in this subpart. If a loan recipient is deemed to be certified or loses its deemed status and is no longer deemed as certified to participate in the Exchanges, CMS or an entity designated by CMS will provide notice to the Exchanges in which the loan recipient offers CO–OP qualified health plans.

(f) *Conversions.* The loan recipient shall not convert or sell to a for-profit or non-consumer operated entity at any time after receiving a loan under this subpart. The loan recipient shall not undertake any transaction that would result in the CO–OP implementing a governance structure that does not meet the standards in this subpart.

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: July 15, 2011.

Marilyn Tavenner,

Principal Deputy Administrator and Chief Operating Officer, Centers for Medicare & Medicaid Services.

Approved: July 15, 2011.

Kathleen Sebelius,

Secretary, Department of Health and Human Services.

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DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Part 654

[Docket No. 110707375–1374–01]

RIN 0648–BB07

Fisheries of the Caribbean, Gulf of Mexico, and South Atlantic; Stone Crab Fishery of the Gulf of Mexico; Removal of Regulations

AGENCY: National Marine Fisheries Service (NMFS), National Oceanic and Atmospheric Administration (NOAA), Commerce.

ACTION: Proposed rule; request for comments.

SUMMARY: NMFS proposes to repeal the Fishery Management Plan for the Stone Crab Fishery of the Gulf of Mexico (FMP) and remove its implementing regulations, as requested by the Gulf of Mexico Fishery Management Council (Council). The stone crab fishery takes place primarily in state waters (off the coast of Florida) and Florida's Fish and Wildlife Conservation Commission (FWC) is extending its management into Federal waters. Repealing the Federal regulations would eliminate duplication of management efforts, reduce costs, and align with the President's Executive Order 13563, ''Improving Regulation and Regulatory Review,'' to ensure Federal regulations are more effective and less burdensome in achieving regulatory objectives. The intended effect of this action is to enhance the effectiveness and efficiency of managing the stone crab fishery in the Gulf of Mexico (Gulf).

DATES: Written comments must be received on or before August 19, 2011.

ADDRESSES: You may submit comments on the proposed rule identified by NOAA–NMFS–2011–0140 by any of the following methods:

- *Electronic submissions:* Submit electronic comments via the Federal e-Rulemaking Portal: *http://www.regulations.gov.* Follow the instructions for submitting comments.
- *Mail:* Susan Gerhart, Southeast Regional Office, NMFS, 263 13th Avenue South, St. Petersburg, FL 33701.

Instructions: All comments received are a part of the public record and will generally be posted to *http://www.regulations.gov* without change. All Personal Identifying Information (for example, name, address, etc.) voluntarily submitted by the commenter may be publicly accessible. Do not submit Confidential Business Information or otherwise sensitive or protected information.

To submit comments through the Federal e-rulemaking portal: *http://www.regulations.gov,* click on ''submit a comment,'' then enter ''NOAA–NMFS–2011–0140'' in the keyword search and click on ''search.'' To view posted comments during the comment period, enter ''NOAA–NMFS–2011–0140'' in the keyword search and click on ''search.'' NMFS will accept anonymous comments (enter N/A in the required field if you wish to remain anonymous). You may submit attachments to electronic comments in Microsoft Word, Excel, WordPerfect, or Adobe PDF file formats only.

Comments received through means not specified in this rule will not be considered.

Electronic copies of documents supporting this proposed rule, which include an environmental assessment and an initial regulatory flexibility analysis (IRFA), may be obtained from Southeast Regional Office Web site at *http://sero.nmfs.noaa.gov.*

FOR FURTHER INFORMATION CONTACT: Susan Gerhart, telephone: 727–824–5305 or *e-mail: Susan.Gerhart@noaa.gov.*

SUPPLEMENTARY INFORMATION: The stone crab fishery of the Gulf of Mexico (Gulf) is managed under the FMP. The FMP was prepared by the Council and implemented through regulations at 50 CFR part 654 under the authority of the Magnuson-Stevens Fishery Conservation and Management Act (Magnuson-Stevens Act).

Background

The commercial stone crab fishery is limited primarily to the coastal waters off the State of Florida, with a small amount of landings occurring off of Louisiana and Texas. Florida has actively managed the Florida stone crab fishery since 1929.

The Federal FMP, implemented in 1979, applies only to Federal Gulf waters adjacent to Florida waters. It was originally implemented to reduce gear